STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT JUDAY CREEK LLC	6330 N FIR ROAD GRANGER, IN46530

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R0000	This visit was for a State Residential Licensure Survey. Survey dates: August 8, 9, and 10, 2011 Facility number: 012229 Provider number: 012229 AIM number: N/A Survey Team: Sandra Haws, RN- TC Bobbie Costigan, RN Census Bed Type: Residential: 92 Total: 92 Census Payor Type: Other: 92 Total: 92 Sample: 8 These State Residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 16,2011 by Bev Faulkner, RN	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0006	(f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring.			
	Based on interviews, observations and record reviews, the facility failed to evaluate the residents to determine if they could meet the needs of the residents or to determine if alternate placement was necessary for 4 of 8 residents reviewed for assisted living criteria in a sample of 8. Resident's: #93, #72, #88, #66. Findings include: 1. Review of Resident #93's clinical record on 8/9/11 at 11:00 a.m., indicated diagnoses of, but not limited to, Alzheimer's disease, dementia, depression, and HTN (hypertension).	R0006	1. Resident #93 was discharged to a skilled health facility on 7/3/2011. DON and Administrator have met with the daughter/POA of resident #72 and alternative healthcare arrangements have been made. Resident #72 will be moved on 8/31/2011. DON met with Resident #88's son/POA regarding service plan. Residents family will provide outside services to assist resident during meal services. Resident requires assist of one at most transfers. Resident #88 was discharged from hospice services on 8/19/2011 as condition has improved and no longer qualifies for hospice care. Resident is continent at times and incontinent	09/15/2011

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	Resident #93's chart indicated she was admitted on 4/29/10 and discharged on 7/3/11 to a ECF (extended care facility). The Nursing Notes from 12/1/10 to 7/3/11 indicated that Resident #93 experienced 31 falls. The Weight Flow Sheet started 4/29/10 indicated the admission weight was 144.0 lbs (pounds). The last weight recorded before discharge on 6/29/11 was 105.6 lbs. Resident #93 experienced a 38.4 lb weight loss in approximately 14 months. The Plan of Care from (Name) Hospice, dated 10/28/10, stated, "...Weight is 154 lbs at home, 144 lbs April 2010 and currently 119.6 lbs. Patient is now incontinent of bowel and bladder and is unable to converse intelligently. Her behaviors have increased showing increased out burst, hallucinations and delusions. She has become a fall risk, having an unsteady gait...." The Interdisciplinary Narrative Notes from (Name) Hospice, dated 1/5/11 at 1:45 p.m., stated, "...Became agitated and attempted to hit me when attempting to toilet...must be fed...." The Interdisciplinary Narrative Notes from (Name) Hospice, dated 1/13/11 at 1:40 p.m., stated, "...Pt (patient) was		at times.Resident #66 is continent of both bowel and bladder, feeds self all meals, ambulates with rollator walker independently, and transfers with stand by assist. 2. Each resident will be evaluated to determine if the facility can meet the needs of the residents or determine if alternative services or placement is necessary.3. All residents will be assessed quarterly or as needed by DON and/or designee to determine if the residents needs can be met by the facility, which will include if alternative services or placement is necessary.4. The Administrator and/or designee will monitor that residents are assessed as needed to determine that residents needs can be met by the facility, and ensure as needed that either additional services are obtained or alternative placement is obtained as needed by reviewing the residents assessments prior to admission and then quarterly. The DON and/or designee will report findings of any assessments of residents care needs that cannot be met to the Administrator and appropriate measures will be taken monthly ongoing.	

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	combative immediately...very unsteady on feet and attempted to walk almost falling two times. Very diff (difficult) to redirect...." The Plan of Care from (Name) Hospice, dated 1/22/11, stated, "...Has lost 12.6 lbs in 2 1/2 months...Intake 25-100%...Unable to make needs known. Frequent falls past 2 weeks with bruising...Incontinent of bowel and bladder. Resistive and combative of care...." The Interdisciplinary Narrative Notes from (Name) Hospice, dated 1/26/11 at 12:30 p.m., stated, "...agitation and patient is becoming increasingly combative...pt (patient) found on back gait very unsteady and shuffled...." Review of a resident to resident incident on 2/28/11 indicated Resident #93 walked up to another resident sitting on a sofa and struck the other resident with an open hand across the face. The Nursing Notes, dated 3/24/11 at 8:00 a.m., stated, "...Res (resident) was up all shift on 11-7 shift (sic). Res is still agitated...." The Nursing Notes, dated 3/30/11 at 1:40 a.m., stated, "...Resident was found on			

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	floor by the aide, she was in the hallway, on her back, she was moaning & (and) had c/o (complaint of) pain...Resident was taken to the nurses station for monitoring...." No documentation was made to indicate that the family or doctor was notified. The Resident Incident Log provided by the Administrator on 8/9/11 did not indicate that the Administrator or DON (Director of Nursing) was made aware of the fall. Review of a resident to resident incident on 3/31/11 indicated Resident #93 took another resident's walker while she was using it and then struck her. The Interdisciplinary Narrative Notes from (Name) Hospice, dated 4/6/11 at 11:35 a.m., stated, "...kept eyes closed thru most of meal needed cueing to swallow food...." The Plan of Care from (Name) Hospice, dated 4/13/11, stated, "...Dependent for all ADLs. Ambulates with eyes closed. Walks into walls. Frequent falls with no injuries. Becomes extremely agitated and combative at times. Alert to person only. Speech nonsensical...." The Interdisciplinary Narrative Notes from (Name) Hospice, dated 4/27/11 at 1:35 p.m., stated, "...upon arrival, walking			

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	into walls c (with) eyes closed, shuffling gait...became combative and agitated...." The Nursing Notes, dated 4/29/11 at 2:00 p.m., stated, "Resident walked up behind another resident (name), she grabbed his shirt from behind, (name) attempted to pull away and (name) struck him in the back c (with) a closed fist 3x (times)...." The Nursing Notes, dated 5/25/11 at 5:30 p.m., stated, "Res had increased agitation, irritability, increased competitiveness. Res found to be unsteady on her feet...." The Case Manager Notes, dated 5/26/11 at 5:00 p.m., stated, "...Resident ambulates independently, constantly moving, rest periods not tolerated, Resident will sit for meals with constant redirection, resident tires easily from long periods of ambulation...." The Case Manager Notes, dated 6/8/11 at 2:30 p.m., indicated resident experiencing frequent falls. Stated, "...suggested w/c (wheelchair) c (with) anti-rollbacks, tilted seat, + (and) tilted seat cushion...." During an interview with the Administrator on 8/10/11 at 11:20 a.m., she indicated there were no dietary notes from their dietician available for Resident #93.			

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	2. During a tour of the Alzheimer's unit accompanied by the Director of Nursing on 8/8/11 at 12:00 p.m., an observation was made of Resident # 72 sitting in the dining room, her head bent down, and her arms crossed. CNA # 2 was observed sitting next to the resident trying to feed the resident her lunch. The resident did not try and feed herself, her head was observed to stay down and her arms stayed crossed over her chest. The resident was not able to eat her lunch. On 8/9/11 at 8:00 a.m. through 9:05 a.m., Resident # 72 was observed sitting in the dining room for breakfast. Her head was again observed to be hanging down, and her arms crossed over her chest. CNA # 3 was observed sitting next to the resident to feed her. CNA # 3 would hold a spoon full of food and just sit and look around the room. The CNA did not attempt to speak or stimulate the resident to try and get her to eat. He was observed to place the resident's hand on his hand and just leave it there, not putting the spoon or fork to her mouth. CNA # 3 was observed to get up and leave the resident three different times to assist other residents. The resident was not able to eat her breakfast. During an interview with the Director of Nursing on 8/9/11 at 9:30 a.m., regarding	R0006	1. Resident #93 was discharged to a skilled health facility on 7/3/2011. DON and Administrator have met with the daughter/POA of resident #72 and alternative healthcare arrangements have been made. Resident #72 will be moved on 8/31/2011. DON met with Resident #88's son/POA regarding service plan. Residents family will provide outside services to assist resident during meal services. Resident requires assist of one at most transfers. Resident #88 was discharged from hospice services on 8/19/2011 as condition has improved and no longer qualifies for hospice care. Resident is continent at times and incontinent at times.Resident #66 is continent of both bowel and bladder, feeds self all meals, ambulates with rollator walker independently, and transfers with stand by assist. 2. Each resident will be evaluated to determine if the facility can meet the needs of the residents or determine if alternative services or placement is necessary.3. All residents will be assessed quarterly or as needed by DON and/or designee to determine if the residents needs can be met by the facility, which will include if alternative services or placement is necessary.4. The Administrator and/or designee will monitor that residents are assessed as needed to determine that residents needs can be met by the facility, and ensure as needed	09/15/2011

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	the resident not being able to feed herself and CNA # 3 not putting an effort into making sure the resident ate something, she indicated she would speak with CNA # 3. She further indicated she has told them to try "hand over hand" technique to try and get them to eat. Resident # 72 was observed sitting at an "L" shaped counter area in front of where the food was dished up. The residents seated in this area were observed needing assistance to be fed by staff. During an interview with the Director of Nursing on 8/9/11 at 9:40 a.m., regarding this area, if it was a "feeding table area" she indicated usually residents who need to be fed or cued to eat will sit there but not always. Resident # 72's record was reviewed on 8/8/11 at 1:00 p.m. The resident's record indicated diagnoses of, but not limited to; Alzheimer's disease, hearing loss, glaucoma, and dementia with delusions. The resident's record indicated she was admitted to the facility on 4/14/10. Her admission weight was recorded at 163.8 pounds. Her weight for June 2011 was recorded at 147.8 pounds. A dietary note, dated 1/13/11, indicated "...Wt (weight) target 160 +/- 5 # (pounds) currently in target range- would like to prevent undesirable wt gain- but overall		that either additional services are obtained or alternative placement is obtained as needed by reviewing the residents assessments prior to admission and then quarterly. The DON and/or designee will report findings of any assessments of residents care needs that cannot be met to the Administrator and appropriate measures will be taken monthly ongoing.	

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	appears to have an unplanned downward trending." Dietary note, dated 7/28/11, indicated "...loss of 20.4 pounds = 13% over last 6 months...requiring hand over hand assist at meals...inadequate food fluid intake r/t (related to) functional decline...may need more skilled intervention and direct staff feeding...." Review of Nursing Notes from 1/30/11 to 7/11 indicated the following; 1/30/11- "8:30 A (a.m.) Resident was walking to dining room with staff assist and lost her balance. Staff lowered her to the floor...." 5/24/11- "8 p.m. Res (resident) had ^ (increased) irritability and combative while giving meds. Res was taken to room to toilet and combative to nurse...." 6/14/11- "Res fell in activities room unwitnessed...." 6/27/11 8:30 a.m.- "While staff was assisting resident to the dining room this morning she was walking too fast and stumbled over her feet. She fell in prone position with face flat on the floor. 7/2/11 8 a.m.- Resident was found on the floor next to her bed at 7:00 a.m. Possible rolled out off the bed....will need bed rails...bruise noted to coxyc (sic) area, LL			

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	(left lower) back...L (left) foot...." Review of a Hospice note, dated 7/14/11, indicated " ...Staff states pt (patient) needs 2 people to stand and pivot and must be dressed and fed." Review of Resident # 72's service plan, dated 7/11, indicated for mobility she requires to be escorted to most daily meals, activities and outings. For transfers, requires assistance with most transfers. For dressing and morning care; requires assistance with dressing each morning. For personal hygiene/grooming; she requires total assistance with grooming, lotion, nails...or extended care. For toileting; wears depends, is incontinent of urine and bowel most always. For dining; requires staff to verbal cue, cut up food into bite size portions, hand over hand guidance. Is resistive to care. An observation was made on 8/10/11 at 10:50 a.m., accompanied by CNA # 4 of Resident # 72 transferring from her wheelchair to her bed. The CNA used both hands pulling the resident up by her hands from the wheelchair and placed her in her bed. The CNA had to lift the resident's legs onto the bed. During an interview with the CNA at this time regarding the resident's care needs, she			

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	indicated she needs total assistance with toileting as she's incontinent, transfers and daily care needs. 3. During an interview with the Director of Nursing on 8/8/11 at 12: 30 p.m., she indicated Resident # 88 has late stage Alzheimer's disease,and needed assistance with transfers and daily care. She indicated the resident was incontinent of bowel and bladder and needed to be checked and changed every two hours. She further indicated the resident falls and has behaviors towards others. Resident # 88's record was reviewed on 8/8/11 at 1:00 p.m. The resident's record indicated diagnoses of, but not limited to; Dementia with behavioral disturbance, and chronic pain. On 8/9/11 at 12:00 p.m., an observation was made of Resident # 88 sitting in the dining room at the L shaped counter with her food in front of her. The Director of Nursing indicated at that time the resident needed cueing to eat. At 12:05, the Director of Nursing sat down beside the resident putting the spoon in the resident's hand and assisted feeding her by putting the spoon to the resident's mouth. The resident was observed not eating. A dietary note, dated 4/21/11, indicated			

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	the resident's weight was down 14.2 pounds or 11% in 8 months. The resident's weight flow sheet indicated her weight on admission was 128.2 pounds on 8/4/10. The weight taken on 8/3/11 indicated 107.8 pounds, a 20.4 pound weight loss in one year. An observation was made on 8/10/11 at 11:05 a.m., accompanied by CNA # 4 of Resident # 88 transferring from her wheelchair to her recliner. The CNA pulled the resident up by putting her arm under the resident's arm and pulled her to a standing position from the wheelchair. The resident was observed to be very unsteady and plopped down in the recliner. The CNA had to lift the leg rest up for the resident. During an interview with the CNA, at this time regarding the resident's care needs, she indicated she needs total assistance with toileting as she's incontinent, needs assistance with transfers and daily care needs. Nurses Notes dating from 1/11 to 4/11 indicated the following; 1/14/11 6:30 p.m., "Res was found on the bathroom floor...no injuries." 1/29/11 4:30 a.m., "Res found on floor of room covered up with a blanket. BP (blood pressure) 152/105...unable to			

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	assess extremities and pupils due to resident being drowsy and not cooperative with following directions...." 3/21/11 4 p.m., "Resident experienced severe diarrhea. Upon evaluation, resident found to be dehydrated...." The record indicated the resident was sent to the emergency room and was admitted to the hospital." 4/26/11 3:00 p.m., " CNA called nurse to activities room Res in Wheelchair and had a spasm/tremor in her hands and feet, her legs caught and she fell face first out of the wheelchair. Abrasion noted to forehead...." 4/30/11 9:30 a.m. " Res in dining room with her wheelchair eating breakfast. She attempted to get out of chair and fell to the floor. She did hit head on floor and has c/o (complains of) a headache...." The resident's Service Plan, dated 6/20/11, indicated for mobility, the resident requires escort to most daily meals, activities and outings. For transfers; the resident requires assistance with most transfers, for hygiene and grooming; the resident requires total assistance with grooming, lotion ... or extended care. For toileting/incontinence; the resident is incontinent of urine and bowel most			

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	always. For eating; the resident requires care staff to verbal cue, cut food into bite size portions, requires assistance with dining...for care during the night; extended service (e.g. hourly checks). Resistive to care, easily agitated, disturbances create need for staff modification. 4. During a tour of the Alzheimer's unit on 8/8/11 at 12:00 p.m., accompanied by the Director of Nursing, she indicated Resident # 66 falls and has a history of fracturing her arm from a fall, and has experienced weight loss. She further indicated the resident needs assistance with toileting and transfers. On 8/9/11 at 12:00 p.m., an observation was made of Resident # 66 sitting in the dining room at the L shaped counter without any food in front of her. All of the other residents at the counter had been served and were either being fed or had eaten. Upon questioning the Director of Nursing regarding Resident # 66 without food, she indicated to the staff to get the resident's lunch. Resident # 66's record was reviewed on 8/9/11 at 1:20 p.m. The resident's record indicated diagnoses of, but not limited to; dementia, tremors and hypertension. The resident's record indicated she was			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	admitted to the facility on 8/17/10. The resident's weight flow sheet indicated her admitting weight was 117.2 pounds on 8/17/10. The weight record indicated on 8/3/11 her weight was 97.4 pounds. A dietary note, dated 1/13/11, indicated "...Significant wt loss (13% from 8/10)...prompted cue at meals...." Review of a nurses note, dated 1/6/11 3 p.m., indicated "...Res is weak, unable to stand alone. Unable to sit upright without assistance or prop...bruising noted on L arm and reddened area noted on L hipbones. Res is able to hold a conversation but states that she is in her home in Chicago." A Nurses Note, dated 1/6/11 at 7 p.m., "...biox 78% (normal 98%) res will not keep nasal cannula in place. Res still weak and unable to sit upright...refused solid food...." The record lacked documentation to indicate the physician was made aware of the critical biox or weakness. The note continued at 11 p.m. and on 1/7/11 at 3 a.m. indicating the resident was still very weak and unable to sit upright without assistance. On 1/8/11 at 10 a.m., the Nurse Note indicated "While checking on res,			

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	paleness was noted to bil (bilateral) feet and hands, face and lips...R 28, ...biox 80% on 3 L 02 n/c while lying flat in bed....res c/o sob (shortness of breath)...." The record indicated the resident had to be taken to the hospital with a diagnosis of pneumonia. 1/9/11 7:30 p.m., "At 7 p.m. staff heard res yelling for help from the hallway. Upon entering the room res was kneeling on the L knee. Res reported trying to get things packed up...." 1/15/11- Note indicated the resident was ...."found by activities on the floor by the television...Res stated she was trying to get out of the chair back into her wheelchair and slid on to the floor...sp02 69 -70%...." 6/26/11- The nurses note indicated the resident had a fall while pushing her walker. Note on 6/27/11 indicated the resident had a left shoulder fracture from the fall. A physician's note dated 7/21/11, indicated "...Pt had fallen...on 6/26 and xray showed nondisplaced fracture left humeral head and neck fracture...." 7/7/11- Nurse note indicated the resident slid out of her wheelchair in the activity room.			

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	Review of a physician's progress note from the hospital, dated 2/8/11, indicated "...Pt was hospitalized in early January for pneumonia, sepsis, acute renal failure acute respiratory distress, hypokalemia, hypomagnesemia, leukocytosis, malnutrition...She went to get something on the floor and leaned too far forward, bumping her head on 2/3. She did not have LOC (loss of consciousness) or dizziness, but her hearing had been diminished since then...." The resident's service plan, dated 4/11, indicated for mobility, the resident requires to be escorted to most daily meals, activities and outings. For transfers, the plan indicated the resident requires assistance with most transfers. For dressing and care, the resident requires assistance with dressing each morning. The facility's policy titled Residency Requirements, dated 8/25/10, was reviewed on 8/9/11 at 11:00 a.m. The facility policy indicated "...To be in compliance with state and federal laws...must be able to transfer independently unless at level IV assisted living services and then must be able to transfer with the assistance of one person, must be able to manage his/her activities of daily living independently or with the			

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	assistance available through all levels of assisted living services...must not exhibit behavior problem(s) disturbing to other residents. If the behavior problem(s) can be controlled as a result of behavior management, medication, family, home health agency, or mental health intervention, the resident may be permitted to remain...must not be a safety risk to self or others, must be able to eat independently (some meal assistance is available). Final determination regarding eligibility rests with the Executive Director...If the needs cannot be met with the services available, then the prospective resident would not qualify for residency nor the current resident for continued residency...."			

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R0029	(d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, interviews and record review, the facility failed to ensure a resident's rights were honored or respected related to a staff member demanding a resident get up and out of bed when they didn't feel well and desired to rest for 1 of 8 residents reviewed for resident rights in a sample of 8. Resident # 84 Findings include: During a tour of the facility on 8/8/11 at 12:00 noon, accompanied by the Director of Nursing, she indicated Resident # 84 was in her room. Staff had indicated she did not want to come out to lunch and wanted to stay in her room. The Director of Nursing indicated Resident # 84 had no behaviors, no falls, and was independent with most care.	R0029	1. Resident #84's service plan (Attachment A) has been updated to include - resident resistive to care, resident prefers to wake naturally, approach with different staff as needed. Family to assist with approach. DON immediately began investigation of staff involved. C.N.A. 2 was interviewed with surveyor present. C.NA. 2 reported that she did attempt to provide care for Resident #84, saying it was time to get up, while pulling back residents blankets to assist resident. Resident began yelling at C.N.A. to leave and that she (resident) did not want to get up. C.N.A. 2 reported she covered resident up and left apartment to get a fellow C.N.A. to assist.DON and Administrator interviewed C.N.A. 2 in Administrator office, C.N.A. reported she did attempt to provide a.m. care for resident #84, saying to resident it was time to get up, while removing blankets from resident, and	09/15/2011

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	Resident # 84 was visited at 12:15 p.m., accompanied by the Director of Nursing. Upon entrance into Resident # 84's room, the resident was observed sitting in a chair with a blanket over her lap. Her bed blanket and sheet was observed hanging over a wheelchair at the corner near the foot of the resident's bed. The resident looked shaken and angry upon entrance. The Director of Nursing asked the resident how she was doing and if she wanted to come to lunch. The resident responded loudly "No, and that girl had better never come into my room ever again. She better never come in here!" She indicated a CNA came in and threw her covers off of her and tossed them over there (on the wheelchair) and said "Get out of bed!" The resident stated she told her she didn't feel well and didn't want to get up yet. She indicated the CNA insisted she get up so she ordered her out of her room and if she didn't go, she would hit her with her cane. She further indicated the CNA never bothered to give her blankets back and they were out of her reach. She indicated she was cold until someone else came in. Upon exiting the resident's room, the Director of Nursing indicated this type of behavior from staff makes her angry. She looked at the schedule and found CNA # 2		placing them on residents wheelchair at the corner beside the foot of the residents bed. The resident immediately became upset, and yelled at the C.N.A. to leave her apartment. C.N.A. reported she immediately left the apartment to go ask a fellow C.N.A. for assistance. C.N.A. reported she was nervous by surveyors presence in earlier interview, and made an error in reporting she covered resident back up. C.N.A. reported that resident was yelling at her to leave and C.N.A. did not want to further agitate the resident by not leaving as resident had told her to. C.N.A. 2 did immediately go get assistance of fellow C.N.A. to assist the resident. Resident #84 scored a 9 on the short portable mental status questionnaire - severe intellectual impairment on 8/10/2011 (Attachment B) - performed by DON, and a 9 on 8/9/2010 - severe intellectual impairment assessment completed by previous DON (Attachment C) C.N.A. 2 was re-educated on Resident Rights, Resident abuse and dealing with behaviors of residents with Alzheimer's/Dementia (Attachment D).2. An audit of all current residents service plans will be conducted by DON and/or designee to ensure residents that are resistive to care have appropriate interventions in place. An all staff in-service will be conducted by Area Agency	

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	was the caregiver for Resident # 84. On 8/8/11 at 12:30 p.m., the Director of Nursing requested an interview with CNA # 3, who was the aide who came into the resident's room after the incident happened with CNA # 2 and Resident # 84. CNA # 3 was asked how she found the resident when she came into her room. CNA # 3 indicated the resident was in the middle of the bed without any covers over her. The blanket and sheet was laying on the wheelchair in front of the window at the end of the bed, out of reach of the resident. She further indicated the resident was very upset. The Director of Nursing and the Administrator requested an interview with CNA # 2. CNA # 2 indicated she came into Resident # 84's room, it was about 10:30 a.m. She indicated the resident didn't want to get up and said to get out. CNA # 2 indicated she covered the resident back up and left her room. On 8/10/11 at 10:15 a.m., another interview was conducted with the resident. She felt more relaxed and would talk about the incident. She stated "She came into my room and tore my covers off of me and told me to get out of bed! I told her I wasn't feeling good and didn't want to get up yet. She kept saying to me you can do it, you can do it, now get up!"		Ombudsman on Resident Rights on 9/15/2011.3. Residents service plans will have resident behaviors and appropriate interventions documented. Facility will continue with at a minimum pre-employment and annual in-service on Resident Rights.4. The Hearth at Juday Creek will continue to monitor potential for resident abuse/rights issues on an individual basis, during the department leader staff meetings and through the daily review of the 24 hour shift report in staff meetings for abuse/resident rights concerns related to abuse and neglect. The shift nurses will monitor for potential abuse/neglect during the normal rounding process, and report any concerns to the DON or Administrator immediately and by documenting on the 24 hour concern report ongoing. The Administrator and the DON will confer to review any allegation and make recommendations for any changes necessary to the monitoring process weekly for one month and then monthly thereafter.	

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	The resident stated the CNA scared her and wanted her to leave but she would keep insisting she get out of bed. Resident # 84 indicated she yelled at the CNA to get out of her room or she would hit her with her cane. The resident stated she told me "Go ahead and I will report you." Resident # 84 indicated the CNA told her she could get her blankets herself. The resident indicated she was not able to reach them as they were thrown out of her reach. The resident kept repeating "She better never come back into my room." The resident stated "people don't realize when you're old and helpless, it scares us to have someone treat you like that." Resident # 84's record was reviewed on 8/8/10 at 2:00 p.m. The resident's record indicated diagnoses of, but not limited to; diverticulosis, hypothyroidism and dementia. The resident's service plan, dated 8/11, indicated she is independent with her personal care and hygiene. She needs occasional assistance with ambulation, dressing and grooming and is continent of bowel and bladder. A resident interview was conducted on 8/10/11 at 10:00 a.m., and found the resident to be alert and oriented and answered questions appropriately.			

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R0036	(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to notify the physician of a significant change of condition involving falls and critical blood pressures for 2 of 8 residents reviewed for significant changes in a sample of 8. Resident's: #93, #88. Findings include: 1. Review of Resident #93's clinical record on 8/9/11 at 11:00 a.m., indicated diagnoses of, but not limited to, Alzheimer's disease, dementia, depression, and HTN (hypertension). Resident #93's chart indicated she was admitted on 4/29/10 and discharged on 7/3/11 to a ECF (extended care facility). The Nursing Notes, dated 3/30/11 at 1:40 a.m., stated, "...Resident was found on floor by the aide, she was in the hallway, on her back, she was moaning & (and) had c/o (complaint of) pain...Resident was taken to the nurses station for	R0036	1. Resident #93 no longer resides in the facility.Facility staff contacted Resident #88's physician for parameters to notify physician of changes in residents blood pressure. Order received to hold medication if systolic blood pressure less than 100 and heart rate less than 60.2. A in-service for licensed nursing staff regarding protocol for notification of physician and families when a resident incident or change of condition occurs.3. A in-service for licensed nursing staff regarding protocol for notification of physician and families when a resident incident or change of condition occurs.4. DON or Case Manager will monitor the follow up on all incidents and changes of condition to ensure appropriate notification on an individual basis, during the department leader staff meetings and through the daily review of the 24 hour shift report in staff meetings. The Administrator and the DON and/or designee will confer to review any incident or change of	09/15/2011

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	monitoring...." No documentation was available to indicate that the family or doctor was notified. During an interview with the Administrator on 8/10/11 at 11:20 a.m., she indicated there was no documentation available to show the physician was notified of Resident #93's fall. 2. Resident # 88's record was reviewed on 8/8/11 at 1:00 p.m. The resident's record indicated diagnoses of, but not limited to; Dementia with behavioral disturbance, and chronic pain. Nurses notes dating from 1/11 to 4/11 indicated the following; 1/14/11 6:30 p.m. "Res was found on the bathroom floor...no injuries. 1/27/11 5:30 p.m.- "...BP (blood pressure) 271/162 (1st check) sp02 (oxygen level in the blood, normal 98%) 88%. 2nd check = BP 238/98 sp02 92%. Had dinner in dining area, continues to be lethargic. Will continue to monitor." The notes lack documentation indicating the physician was notified of the critical blood pressures. During an interview with the Director of Nursing and the Administrator on 8/9/11 at 4:30 p.m., regarding the resident's		condition without appropriate follow up and make recommendations for any changes necessary to the monitoring process weekly for one month and then monthly for six months.	

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	critical blood pressure readings and if the physician had been notified as nothing was documented in the resident's record. The Director of Nursing or the Administrator gave no response. 1/28/11-3:30 p.m. "...Res very lethargic this a.m. Ate approx (approximately) 10% of breakfast...10%- 15% of her lunch...." The record failed to indicate the physician had been notified of the lethargy. 1/28/11 7:00 p.m.- "...Res is lethargic and refuses to eat dinner...continues to be tired and lethargic during entire shift." The record lacked documentation to indicate the physician had been notified of the lethargy the entire shift, or lack of food intake. 1/29/11 4:30 a.m.- "Res found on floor of room covered up with a blanket. BP (blood pressure) 152/105...unable to assess extremities and pupils due to resident being drowsy and not cooperative with following directions...." 3/8/11 8:00 p.m.- "Four attempts to give meds the resident refused and became agitated. Throughout shift the resident was in a weak state and did not eat well or drink, VS (vital signs) were taken at 5:30 p.m. P (pulse) 81, R (respirations) 26, 02 (oxygen level) 96%, BP 182/11 and that			

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	was in a resting state." The record failed to indicate the physician had been notified of the weakness and critical blood pressure. 3/21/11 4 p.m. " Resident experienced severe diarrhea. Upon evaluation, resident found to be dehydrated...." The record indicated the resident was sent to the emergency room and was admitted to the hospital. 4/26/11 3:00 p.m. " CNA called nurse to activities room Res in Wheelchair and had a spasm/tremor in her hands and feet, her legs caught and she fell face first out of the wheelchair. Abrasion noted to forehead...." 4/29/11 2:00 p.m. " CNA reported to nurse that resident was sitting in w/c (wheelchair) and when she tried to walk she fell to her knees...." The documentation failed to indicate the physician had been notified. 4/30/11 9:30 a.m. " Res in dining room with her wheelchair eating breakfast. She attempted to get out of chair and fell to the floor. She did hit head on floor and has c/o (complains of) a headache.... The resident's Service Plan, dated 6/20/11, indicated for mobility, the resident			

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	requires escort to most daily meals, activities and outings. For transfers; the resident requires assistance with most transfers, for hygiene and grooming; the resident requires total assistance with grooming, lotion ... or extended care. For toileting/incontinence; the resident is incontinent of urine and bowel most always. For eating; the resident requires care staff to verbal cue, cut food into bite size portions, requires assistance with dining...for care during the night; extended service (e.g. hourly checks). Resistive to care, easily agitated, disturbances create need for staff modification.			
R0052	(v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure a resident was protected from intimidation (abuse) from a staff member resulting in emotional distress leaving the resident fearful of the staff member for 1 of 1 residents reviewed for abuse in a sample of 8. Resident # 84	R0052	1. Resident #84's service plan (Attachment A) has been updated to include - resident resistive to care, resident prefers to wake naturally, approach with different staff as needed. Family to assist with approach. DON immediately began investigation of staff involved. C.N.A. 2 was interviewed with surveyor present. C.N.A. 2 reported that	09/15/2011

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	Findings include: During a tour of the facility on 8/8/11 at 12:00 noon, accompanied by the Director of Nursing, she indicated Resident # 84 was in her room. Staff had indicated she did not want to come out to lunch and wanted to stay in her room. The Director of Nursing indicated Resident # 84 had no behaviors, no falls, and was independent with most care. Resident # 84 was visited at 12:15 p.m., accompanied by the Director of Nursing. Upon entrance into Resident # 84's room, the resident was observed sitting in a chair with a blanket over her lap. Her bed blanket and sheet was observed hanging over a wheelchair at the corner near the foot of the resident's bed. The resident looked shaken and angry upon entrance. The Director of Nursing asked the resident how she was doing and if she wanted to come to lunch. The resident responded loudly "No, and that girl had better never come into my room ever again. She better never come in here!" She indicated a CNA came in and threw her covers off of her and tossed them over there (on the wheelchair) and said "Get out of bed!" The resident stated she told her she didn't feel well and didn't want to get up yet. She indicated the CNA		she did attempt to provide care for Resident #84, saying it was time to get up, while pulling back residents blankets to assist resident. Resident began yelling at C.N.A. to leave and that she (resident) did not want to get up. C.N.A. 2 reported she covered resident up and left apartment to get a fellow C.N.A. to assist.DON and Administrator interviewed C.N.A. 2 in Administrator office, C.N.A. reported she did attempt to provide a.m. care for resident #84, saying to resident it was time to get up, while removing blankets from resident, and placing them on residents wheelchair at the corner beside the foot of the residents bed. The resident immediately became upset, and yelled at the C.N.A. to leave her apartment. C.N.A. reported she immediately left the apartment to go ask a fellow C.N.A. for assistance. C.N.A. reported she was nervous by surveyors presence in earlier interview, and made an error in reporting she covered resident back up. C.N.A. reported that resident was yelling at her to leave and C.N.A. did not want to further agitate the resident by not leaving as resident had told her to. C.N.A. 2 did immediately go get assistance of fellow C.N.A. to assist the resident. Resident #84 scored a 9 on the short portable mental status questionnaire - severe intellectual impairment on 8/10/2011 (Attachment B) -	

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	insisted she get up so she ordered her out of her room and if she didn't go, she would hit her with her cane. She further indicated the CNA never bothered to give her blankets back and they were out of her reach. She indicated she was cold until someone else came in. Upon exiting the resident's room, the Director of Nursing indicated this type of behavior from staff makes her angry. She looked at the schedule and found CNA # 2 was the caregiver for Resident # 84. On 8/8/11 at 12:30 p.m., the Director of Nursing requested an interview with CNA # 3, who was the aide who came into the resident's room after the incident happened with CNA # 2 and Resident # 84. CNA # 3 was asked how she found the resident when she came into her room. CNA # 3 indicated the resident was in the middle of the bed without any covers over her. The blanket and sheet was laying on the wheelchair in front of the window at the end of the bed, out of reach of the resident. She further indicated the resident was very upset. The Director of Nursing and the Administrator requested an interview with CNA # 2. CNA # 2 indicated she came into Resident # 84's room, it was about 10:30 a.m. She indicated the resident didn't want to get up and said to get out.		performed by DON, and a 9 on 8/9/2010 - severe intellectual impairment assessment completed by previous DON (Attachment C). The facility determined there was no abuse or neglect to Resident #84, in the investigation process performed by the DON & Administrator, which included interviews of the surveyor, C.N.A. 2, other staff, and resident's family. C.N.A. 2 was re-educated on Resident Rights, Resident abuse and dealing with behaviors of residents with Alzheimer's/Dementia (Attachment D).2. An audit of all current residents service plans will be conducted by DON and/or designee to ensure residents that are resistive to care have appropriate interventions in place. An all staff in-service will be conducted by Area Agency Ombudsman on Resident Rights on 9/15/2011.3. Residents service plans will have resident behaviors and appropriate interventions documented. Facility will continue with at a minimum pre-employment and annual in-service on Resident Rights.4. The Hearth at Juday Creek will continue to monitor potential for resident abuse/rights issues on an individual basis, during the department leader staff meetings and through the daily review of the 24 hour shift report in staff meetings for abuse/resident rights concerns	

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	CNA # 2 indicated she covered the resident back up and left her room. During and interview with the Administrator on 8/9/11 at 3:30 p.m., regarding CNA # 2's status in the building, she indicated CNA # 2 was sent home immediately. On 8/10/11 at 10:15 a.m. another interview was conducted with the resident. She felt more relaxed and would talk about the incident. She stated "She came into my room and tore my covers off of me and told me to get out of bed! I told her I wasn't feeling good and didn't want to get up yet. She kept saying to me you can do it, you can do it, now get up!" The resident stated the CNA scared her and wanted her to leave but she would keep insisting she get out of bed. Resident # 84 stated she yelled at the CNA to get out of her room or she would hit her with her cane. The resident stated she told me "Go ahead and I will report you." Resident # 84 indicated the CNA told her she could get her blankets herself. The resident indicated she was not able to reach them as they were thrown out of her reach. The resident kept repeating "She better never come back into my room." The resident stated "People don't realize when you're old and helpless, it scares us to have someone treat you like that."		related to abuse and neglect. The shift nurses will monitor for potential abuse/neglect during the normal rounding process, and report any concerns to the DON or Administrator immediately and by documenting on the 24 hour concern report ongoing. The Administrator and the DON will confer to review any allegation and make recommendations for any changes necessary to the monitoring process weekly for one month and then monthly thereafter.	

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	The facility's policy titled Abuse Prevention, undated, was reviewed on 8/9/11 at 1:00 p.m. The policy indicated "Definition of Abuse...Psychological/Emotional Abuse- The willful infliction of mental suffering, by a person in a position of trust with an elder, constitutes psychological/emotional abuses. Examples of such abuse are: verbal assaults, threats, instilling fear, humiliation, or isolation of an elder...."			
R0297	(c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on record review and interview, the facility failed to ensure the ordered medications were available for 2 of 8 residents observed for medications in a sample of 8. Resident's: #103, #56 Findings include: 1. Review of Resident #103's clinical record on 8/9/11 at 1:00 p.m. indicated diagnoses of, but not limited to, dementia, weakness, HTN (hypertension), legally blind, and depression. Resident #103's chart indicated she was admitted on	R0297	1. Resident #103 is currently at a skilled health facility. Resident #56 receives prescribed medications from the VA Pharmacy. All physician ordered medications are in stock.2. All current residents physician orders that facility administers medication for will be audited with medication to ensure that each medication is available to administer.3. Residents and family representatives will be notified that if choosing to use a pharmacy other than facility pharmacy, if medications are not delivered to facility in a timely manner, that the medication will	09/15/2011

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	7/10/10 and discharged 8/5/11 to a mental health hospital. During her stay she had her medication administered by the nursing staff. In the Medication Administration Record for the month of March indicated that the Bystolic (for hypertension) was not available for 6 days. In the Medication Administration Record for the month of April indicated that the Omeprazole (for reflux) was not available for 4 days. In the Medication Administration Record for the month of May indicated that the Bystolic was not available for 2 days. The Zoloft (for depression) was not available for 6 days. In the Medication Administration Record for the month of June indicated that the Colace (for constipation) was not available for 9 days. During an interview with the Administrator and DON (Director of Nursing) on 8/10/11 at 11:20 a.m., indicated they were not aware that Resident #103's medications were unavailable at any time. 2. Review of Resident #56's clinical		be ordered through the facility pharmacy, and that if using the VA Pharmacy, new physician orders may and will be ordered through facility pharmacy until medication arrives from VA pharmacy mail.4. DON and/or designee will review residents MAR medication administration record) to ensure all medications were available to administer. If any medications are not available the Administrator will be notified for appropriate action. DON or Case Manager will monitor the physician order sheets monthly to ensure appropriate medications available on an individual basis, monthly during medication review. The Administrator and the DON and/or designee will confer to review any physician order without medication available and make recommendations for any changes necessary to the medication ordering process weekly for one month and then monthly for six months.	

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	record on 8/8/11 at 1:00 p.m., indicated diagnoses of, but not limited to, dementia, CVA (cerebral vascular accident), hypercholesterolemia, HTN (hypertension), PVD (peripheral vascular disease), and bilateral femoral popliteal bypass. Resident #56 was admitted on 7/31/10. Resident #56 had his medications administered by the nursing staff. In the Medication Administration Record for the month of May indicated that the Zocor (for high cholesterol) was not available for 9 days. The Buspar (for anti-anxiety) was unavailable for 2 days. In the Medication Administration Record for the month of June indicated that the Urea/lidocaine (for rash) ointment was not available for 3 days. In the Medication Administration Record for the month of July indicated that the Buspar was not available for 4 days. The Urea/lidocaine ointment was unavailable for 1 day. The Zocor was unavailable for 6 days. During an interview with the Administrator and DON (Director of Nursing) on 8/10/11 at 11:20 a.m., indicated they were not aware that Resident #56's medications were			

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	unavailable at any time.			
R0406	(a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observations, interview and record review, the facility failed to ensure the facility was kept sanitary and free from transmission of infection related to a resident going around spitting in the dining room while other residents are eating, spitting in the halls and common areas shared by other residents (Resident # 91) for 1 of 8 residents reviewed for infection control practices in a sample of 8. Findings include: During a tour of the facility on 8/8/11 at 12:00 noon, an observation was made of Resident # 91 sitting in the dining room at a table with three other residents. Resident # 91 was observed to lean over and spit on the floor leaving a wet area of spit next to the other resident. On 8/9/11 at 8:30 a.m., Resident # 91 was observed seated in the dining room for breakfast. The resident was observed spitting on the floor while seated at the table with three other residents. The resident was observed to spit on both	R0406	1. Resident #91 no longer resides in the facility.2. There are currently no other residents living at the facility that spit in the floor.3. Staff will be in-serviced by the DON and/or designee to clean and sanitize any area that a residents body fluids have contacted.4. Department Leaders and Administrator will monitor facility to ensure that any body fluids are cleaned and sanitized appropriately.During the department leader staff meetings, the department leaders and the Administrator will confer to review any incident involving sanitary condition without appropriate follow up and make recommendations for any changes necessary to the monitoring process weekly for one month and then monthly for six months.	09/15/2011

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	sides of his chair. A waste basket was observed setting next to his chair, and he was observed not to spit in. Resident # 91 was observed to get up and walk 3 feet and spit on the dining room floor again. He was observed to walk down the carpeted hallway and spit on the floor. During an interview with the LPN # 7 on 8/9/11 at 8:45 a.m. regarding the wet spit areas on the dining room floor, she indicated this is what this resident does. She summoned for a staff person to sanitize the floor. Other residents were observed walking through the spit before the floor could be sanitized. Resident # 91's record was reviewed on 8/10/11 at 11:00 a.m. The resident's record indicated diagnoses of, but not limited to; dementia, diabetes, and agitation. The resident's Service Plan, dated 7/6/10, indicated he was independent with ambulation, transfers and dressing, he was continent with bowel and bladder. Judgment and memory are not always good. Needs monitoring and guidance and occasional redirection. Wanders at night. During an interview on 8/10/11 at 10:30 a.m., with CNA # 3 regarding Resident # 91's behavior of spitting all over, she			

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	indicated he walks around and spits everywhere. She indicated they try and keep a waste basket available for him but he doesn't always use it. He walks around so it's hard to know where he spits.			